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8	BEFORE THE		
9	BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS		
10	STATE OF CALIFORNIA		
11			
12	In the Matter of the Accusation Against: Case No. 2011- 963		
13	LINDA ANN MEMMER aka LINDA ANN SPARKES		
14	4242 Bartleson Road ACCUSATION		
15	Sebastopol, CA 95472 Registered Nurse License No. 515000		
16	Respondent.		
17			
18	Complainant alleges:		
19	<u>PARTIES</u>		
20	1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her		
21	official capacity as the Executive Officer of the Board of Registered Nursing, Department of		
22	Consumer Affairs.		
23	2. On or about August 25, 1995, the Board of Registered Nursing issued Registered		
24	Nurse License Number 515000 to Linda Ann Memmer, aka Linda Ann Sparkes ("Respondent").		
25	The Registered Nurse License was in full force and effect at all times relevant to the charges		
26	brought herein and will expire on February 28, 2013, unless renewed.		
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28	///		
	1		

JURISDICTIONAL STATUTES

- 3. This Accusation is brought before the Board of Registered Nursing ("Board"), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.
- 4. Section 2750 of the Code provides in relevant part that every licensee, including licensees holding a license placed in an inactive status, may be disciplined as provided in this Article.
- 5. Section 2764 of the Code provides in relevant part that the lapsing or suspension of a license by operation of law shall not deprive the Board of jurisdiction to proceed with any investigation or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license.

DISCIPLINARY STATUTES AND REGULATIONS

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- "(a) Unprofessional conduct, which includes, but is not limited to, the following:
- "(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
- "(d) Violating or attempting to violate, directly or indirectly . . . any provision or term of this chapter [Nursing Practice Act] or regulations adopted pursuant to it."
 - 7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single

situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

. . .

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

. . .

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed."

. . .

10. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon . . . administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 [commencing with section 11000] of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

2.8

"(e) Falsity, or make grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

COST RECOVERY

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

- 12. "Norco" is an opioid analgesic used to treat moderate to moderately severe pain.

 It is classified as a Schedule III controlled substance pursuant to Health and Safety Code Section 11056, subdivision (e)(4) and is a dangerous drug pursuant to Business and Professions Code Section 4022.
- 13. "Percocet" is an opioid analgesic used to treat moderate to moderately severe pain. It is classified as a Schedule II controlled substance pursuant to Health and Safety Code Section 11055, subdivision (b)(1)(N) and is a dangerous drug pursuant to Business and Professions Code Section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence – Failure To Document Administration of Controlled Substances)

14. Respondent is subject to discipline under Code section 2761(a)(1), on the grounds of gross negligence and/or incompetence in that while employed as a registered nurse at Santa Rosa Memorial Hospital, in Santa Rosa, California, she failed to document the administration of controlled substances withdrawn for patients under her care. Respondent's failure to document the disposition of controlled substances in the patients' Medical Administration Record ("MAR") and/or on the pain flow sheet could have jeopardized the health of said patients by confusing

¹ Norco is a medication that comes in different strengths related to the amount of the opioid hydrocodone. "Norco 5" consists of hydrocodone 5 milligrams with Tylenol 325 milligrams and is prescribed for moderate pain. "Norco 10" consists of hydrocodone 10 milligrams with Tylenol 325 milligrams and is prescribed for severe pain.

other staff as to when patients were last medicated and with what substances. The facts in support of this cause for discipline are as follows:

Patient 3:

- a. On June 21, 2008, at 8:30 a.m., Respondent noted on Patient 3's pain flow sheet that she administered one tablet of Norco 10. However, there was no reference on Patient 3's MAR that this medication had been administered.
- b. At 9:00 a.m., on June 21, 2008, Patient 3 was discharged home. At 10:11 a.m., Respondent withdrew one tablet of Norco 5 for Patient 3. However, Respondent failed to account for disposition of this medication in any hospital or patient record.

Patient 10:

a. On August 7, 2008, at 8:03 a.m., Respondent withdrew one tablet of Norco 5 for Patient 10. However, Respondent failed to account for disposition of this medication in any hospital or patient record.

Patient 15:

a. On August 28, 2008, at 10:05 a.m., Respondent withdrew one tablet of Norco 5 for Patient 15. However, Respondent failed to account for disposition of this medication in any hospital or patient record.

Patient 16:

a. On August 28, 2008, at 9:30 a.m., Respondent administered one tablet of Norco 5 to Patient 16. At 11:02 a.m., Respondent withdrew one tablet of Norco 10 for Patient 16. Four minutes later, at 11:06 a.m., she withdrew one tablet of Norco 5, and at 12:51 p.m.. she withdrew one tablet of Norco 5 for Patient 16. However, Respondent did not record on Patient 16's MAR that she had administered any of these medications. In addition, for the medications withdrawn at 11:02 a.m., and at 11:06 a.m., there was no notation on the pain flow sheet that these medications were administered or any documentation as to their disposition.

Patient 17:

a. On August 30, 2008, at 9:56 a.m., Respondent withdrew one tablet of Percocet 5 for Patient 17. Fifty-two minutes later, at 10:48 a.m., Respondent withdrew another Percocet

tablet for Patient 17. However, Respondent did not record on Patient 17's MAR the administration of either of these medications. Instead she recorded on the MAR that at 3:00 p.m., she administered two Percocet tablets to Patient 17. There was no notation on the pain flow sheet that these medications were administered nor any documentation as to their disposition.

Patient 2:

a. On October 17, 2008, at 8:11 a.m., Respondent withdrew one Norco 5 for Patient 2. However, there was no documentation by Respondent that this medication was administered on the MAR. The medication was noted as being given on the pain flow sheet.

Patient 4:

a. At approximately 11:12 a.m., on October 2, 2008, Respondent withdrew Norco 5 for Patient 4. However, there was no documentation regarding the disposition of this medication.

Patient 7:

a. On September 14, 2008, at 10:21 a.m., Respondent withdrew one tablet of Percocet 5 for Patient 7. However, there was no documentation regarding the disposition of this medication.

SECOND CAUSE FOR DISCLIPLINE

(Gross Negligence/Incompetence - Administration of Controlled Substances More Frequently

Than Ordered and/or Given Without a Physician Order)

15. Respondent is subject to discipline under Code section 2761(a)(1), on the grounds of gross negligence and/or incompetence in that while employed as a registered nurse at Santa Rosa Memorial Hospital, in Santa Rosa, California, she administered controlled substances to patients under her care, more frequently than ordered by the physician and/or without a physician's order. The facts in support of this cause for discipline are as follows:

Patient 3:

- a. On June 19, 2008, Patient 3's physician ordered Norco 5, one tablet every three hours prn for moderate pain or Norco 10, one tablet every three hours prn for severe pain.
- b. On June 21, 2008, at 8:30 a.m., Respondent noted on the pain flow sheet that she had administered one tablet of Norco 10 to Patient 3, who was then discharged home by her physician

at 9:00 a.m. However, after being discharged, Respondent at 10:11 a.m., withdrew one tablet of Norco 10 under Patient 3's name.

Patient 16:

- a. Patient 16 was admitted to Santa Rosa Memorial Hospital on August 26, 2008, for a vaginal hysterectomy. Post-surgically, her physician ordered Norco 5, one tablet every three hours prn for moderate pain or Norco 10, one tablet every three hours prn for severe pain.
- b. On August 28, 2008, at 9:30 a.m., Respondent administered one tablet of Norco 5 to Patient 16. Approximately one and one-half hours later, at 11:02 a.m., Respondent withdrew one tablet of Norco 10 for Patient 16. Four minutes later, at 11:06 a.m., she withdrew one tablet of Norco 5, and at 12:51 p.m., she again withdrew one tablet of Norco 5 for Patient 16.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Grossly Inconsistent and/or Unintelligible Entry in Hospital Records)

Failure to Document Disposition of Controlled Substances)

16. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762 (e), in that while employed as a registered nurse at Santa Rosa Memorial Hospital in Santa Rosa, California, she failed to account for controlled substances withdrawn for patients under her care. The facts in support of this cause for discipline are as follows:

Patient 3:

- a. On June 21, 2008, at 8:30 a.m., Respondent noted on the pain flow sheet that she had administered one tablet of Norco 10 to Patient 3. However, there was no reference on the MAR that Patient 3 had received Norco 10.
- b. On June 21, 2008, at 9:00 a.m., Patient 3 was discharged home. At 10:11 a.m., Respondent withdrew one tablet of Norco 5 for Patient 3. However, Respondent failed to account for disposition of this medication in any hospital or patient record.

Patient 10:

a. On August 7, 2008, at 8:03 a.m., Respondent at withdrew one tablet of Norco 5

for Patient 10. However, Respondent failed to account for disposition of this medication in any hospital or patient record.

Patient 15:

a. On August 28, 2008, at 10:05 a.m., Respondent withdrew one tablet of Norco 5 for Patient 15. However, Respondent failed to account for disposition of this medication in any hospital or patient record.

Patient 16:

a. On August 28, 2008, at 9:30 a.m., Respondent administered one tablet of Norco 5 to Patient 16. At 11:02 a.m., Respondent withdrew one tablet of Norco 10 for Patient 16. Four minutes later, at 11:06 a.m., she withdrew one tablet of Norco 5, and at 12:51 p.m., she again withdrew one tablet of Norco 5 for Patient 16. However, Respondent did not record on Patient 16's MAR that she had administered any of these medications. In addition, for the medications withdrawn at 11:02 a.m., and at 11:06 a.m., there was no notation on the pain flow sheet that these medications were administered.

Patient 17:

a. On August 30, 2008, at 9:56 a.m., Respondent withdrew one tablet of Percocet 5 for Patient 17. Fifty-two minutes later, at 10:48 a.m., Respondent withdrew another tablet of Percocet 5 for Patient 17. However, Respondent did not record on Patient 17's MAR the administration of either of these medications. Instead she recorded on the MAR that at 3:00 p.m., she administered two Percocet tablets to Patient 17. There was no notation on the pain flow sheet that these medications were administered nor any documentation as to their disposition.

Patient 2:

a. On October 17, 2008, at 8:11 a.m., Respondent withdrew one Norco 5 for Patient 2. However, there was no documentation by Respondent that this medication was administered on the MAR. The medication was noted as being given on the pain flow sheet.

Patient 4:

a. At approximately 11:12 a.m., on October 2, 2008, Respondent withdrew one tablet of

1	Norco 5 for Patient 4. However, there was no documentation regarding the disposition of this		
2	medication.		
3	Patient 7:		
4	a. On September 14, 2008, at 10:21 a.m., Respondent withdrew one table	t of	
5	Percocet 5 for Patient 7. However, there was no documentation regarding the disposi	tion of this	
6	medication.		
7	<u>PRAYER</u>		
8	WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,		
9	and that following the hearing, the Board of Registered Nursing issue a decision:		
10	1. Revoking or suspending Registered Nurse License No. 515000 issued	to Linda	
11	Ann Memmer, aka Linda Ann Sparkes.		
12	2. Ordering Linda Ann Memmer, aka Linda Ann Sparkes to pay the Boa	rd of	
13	Registered Nursing reasonable costs of the investigation and enforcement of this case, pursuant to		
14	Business and Professions Code section 125.3.		
15	3. Taking such other and further action as deemed necessary and proper.		
16			
17	DATED: 6/3/201/ Societ & Dailey		
18	Executive Officer Board of Registered Nursing		
19	Department of Consumer Affairs State of California		
20	Complainant		
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